Reset

South Carolina Department of Social Services
ABC Child Care Voucher System

ENHANCED PROVIDER ENROLLMENT FORM

❑ New ❑ Updated

FEIN No.: _____ ( ) **or** Social Security No.: _____ ( )

Provider/Agency Name: _____

Facility Name: (If different from Provider Name) _____

Facility Co. Name: _____ Select County ... Facility Telephone: _____

Director's Name: _____

Alternate Contact Person/Name: _____

Relationship: _____ Telephone: _____

Owner's Name: _____ Telephone: _____

Facility Address: _____
Facility Street Address, P.O. Box or Route Number

_____ _____ _____
City State Zip Code

Payment Address: _____
Facility Street Address, P.O. Box or Route Number

_____ _____ _____ _____
City State Zip Code Payment Telephone

Hours of Operation

❑ 1st Shift _____ ___ M to _____ ___ M
❑ 2nd Shift _____ ___ M to _____ ___ M
❑ 3rd Shift _____ ___ M to _____ ___ M

Days of Operation

M	T	W	TH	F	SA	SU
M	T	W	TH	F	SA	SU
M	T	W	TH	F	SA	SU

1) Provider Type
(Check only one)

❑ Center
❑ Accredited Center
❑ Group Day Care
❑ Family Day Care
❑ Exemption

2) Regulatory Requirement
(Check only one)

❑ License
❑ Approval
❑ Registration
❑ Exemption Letter
❑ DDSN
❑ Military

3) Provider Category
(Check as many as apply)

❑ Church Sponsored
❑ Private-for-profit
❑ Private-nonprofit
❑ Public Facility
❑ Head Start
❑ School District
❑ Less than 4 Hours/Day
❑ Summer Camp

4) Ownership Status
(Check one from each of the 3 categories below)

❑ Minority Owned
❑ Non-Minority Owned

❑ Sole Proprietor
❑ Partnership
❑ Corporation
❑ Other

❑ State Employee
❑ Non-State Employee
❑ Legislator

Regulatory Information: Number: _____ Capacity: _____

If applicable, number of infants under 24 months of age: _____ Date of Expiration: _____

Care Types Provided: (Check all that apply) ❑ 0-2 Full ❑ 3-5 Full ❑ 6-12 Full ❑ 0-2 Half ❑ 3-5 Half ❑ 6-12 Half

Check Here If Provider Is Re-enrolling: ❑ Yes

_____ _____
Program Reviewer Review Date

_____ _____
Provider Enrollment Date Processed By

DSS Form 37108 (FEB 05)